TENNESSEE DEPARTMENT OF HEALTH

OFFICE OF HEALTH STATISTICS

Joint Annual Report Manual for Outpatient Diagnostic Center Facilities

2015

JOINT ANNUAL REPORT MANUAL for Outpatient Diagnostic Center Facilities

2015

STATE OF TENNESSEE
Department of Health
Policy, Planning & Assessment
Office of Health Statistics
Andrew Johnson Tower
2nd Floor
710 James Robertson Parkway
Nashville,TN 37243
615-741-1954

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1. ***Before beginning your report go to the*** https://www.tn.gov/health/article/joint-annual-report-of-outpatient-diagnostic-centers
   website to first download your form and save it with your State ID Number, and Facility Name.
   Example: 00000 John Doe Imaging ODC

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SECTION I

Introduction

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

January 15, 2016

LETTER OF INFORMATION

To: Administrators of all licensed Outpatient Diagnostic Centers

We are pleased to provide your facility with an Excel program for entering data into the Joint Annual Report (JAR). Per Tennessee Code Annotated 68-1-119, Rule 1200-8-35-11, "The Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the Department of Health."

The JAR form in an Excel format, a manual for completing this form, and a "Tips to Avoid Common Errors" sheet can be found at https://www.tn.gov/health/article/joint-annual-report-of-outpatient-diagnostic-centers It is recommended that you read and print these documents before completing your report. The "Tips to Avoid Common Errors" document is also located as a tab on the excel file for your reference.

> ***The Excel file must be saved and renamed with the facility's State ID and Name.** (Renaming example: 00000_ABC Center)
>
> ****Once the Excel file is complete, facilities should check the ERROR tab and resolve any problems before submitting. Files submitted incorrectly will be returned for correction.**

Please note that all facilities are requested to report for the period January 1, 2015 through December 31, 2015. All information submitted should be complete and accurate so that the compiled data will be useful for the legislature, the public, and this department for statistical analyses and health planning processes. The reports are due back to our office by **March 3, 2016**. Any facility that fails to report its data may be issued deficiencies.

Please submit this electronic form upon completion as an attachment in email to: JARODC.Health@tn.gov. If you have any questions concerning the report or have difficulties accessing the website, please contact Cheryl Hines at (615) 532-7888 or by email Cheryl.Hines@tn.gov.

Thank you for the work you do in providing this required data and for all you do for the health and well-being of Tennesseans. We truly appreciate your cooperation.

Sincerely,

Lori B. Ferranti

Lori B. Ferranti, Ph.D, MBA, MSN, RN
Assistant Commissioner, Division of Policy, Planning and Assessment
Tennessee Department of Health

Introduction to Joint Annual Reporting

The Health Statistics Facilities unit collects data from a variety of licensed health facilities through annual reports known as Joint Annual Reports (JARs). Data collected include facility locations, services provided, patient origin by county, and financial indicators.

SECTION II

Rules and Regulations for Reporting

General Reporting Requirements

Per T. C. A. 1200-8-35-11 The Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department. The forms are furnished online to each Outpatient Diagnostic Center by the department each year and the forms must be completed and returned to the department as required.

All facilities are requested to report for the calendar year beginning January 1st through December 31st. Information should be complete and accurate as possible so that the compiled data will be useful for the legislature, the public and the department's statistical analyses and health planning process.

Forty-five days after the facility gets the form from the department it needs to be completed. Any facility that fails to report its data could be issued deficiencies.

Data Editing and Quality Control

The department will review data submitted. Incomplete reports or inaccuracies will be queried. The facility will be asked to investigate these errors and to supply correct information **within 15 working days** of the date that the error is reported to the facility.

Data System Summary

Data Set Name: Outpatient Patient Diagnosis **(**ODC)
Location/Owner of Data Set: Tennessee Department of Health, Office of Health Statistics
Contact Person: **Cheryl Hines** (615) 532-7888 Email Address: Cheryl.Hines@tn.gov
Purpose for Which Data Collected: This system collects and compiles data that will be useful for the legislature, the public and the department's statistical analyses and health planning process.
Process for Accessing Data: Requests for data are handled by Statistical Services. Contact Statistical Services at (615) 741-4939 or HealthStatistics.Health@tn.gov.
Description:
Method of Data Collection: JAR for ODC forms
Percent Return: 95% - 99%
Frequency of Updating: Annually
Years of Data: One
Types of Data Output Available: Excel format files
Cost for Data Output: No
Standard Reports Generated: ODC Joint Annual Reports

Timing and Frequency of Data Submission

All data submitted must be approved by the Department of Health. The Department of Health must receive all required data from the facility 45 days following the close of the calendar year.

Date Sent to Facility	Date Due to TDOH	Reporting Period
January 15, 2016	March 3rd , 2016	January 1st through December 31, 2015

Data reported to the Department of Health should be <u>e-mailed</u> to:

Facilities
Office of Health Statistics
Andrew Johnson Tower
2nd Floor
710 James Robertson Boulevard
Nashville, Tennessee 37243

<u>JARODC.Health@tn.gov</u>

ODC JAR Contacts

Technical questions regarding the Tennessee Outpatient Diagnostic Center Joint Annual Reports should be directed to:

Cheryl Hines*
Facilities Unit
Office of Health Statistics
(615) 532-7888
Cheryl.Hines@ tn.gov

All other JAR inquiries should be referred to:

Trent Sansing
Facilities Unit
Office of Health Statistics
(615) 253-4702
Email to trent.sansing@tn.gov

SECTION III

Schedules

Schedule A – Identification	Facility	Required Fields - Yes

The State Identification number for all ODC facilities is found on the "State ID" sheet of the computer form. This information is protected and cannot be accessed. If the facility had a name change that is not reflected on this data base, please contact Facilities, TN Department of Health. ***See page 11 for all contact information.***

Facility – **State ID**
The **State ID** is accessed from the "drop" box on the computer form. Once the State ID is selected, *the Street Address, City, State, County, and Zip Code* fields will automatically populate the form. This ID will automatically populate Schedule A through Administration Declaration. **DO NOT KEY in this field.** Select the **State ID** from the "drop" box for this field.

Facility – Did the facility's name change during the reporting period?
This is a Required Field and must be answered with "Yes" or "No".
DO NOT KEY in this field. Make the selection from the "drop" box for this field.

If **"Yes"**, key in the facility's Prior Name.

If **"No"**, leave blank.

Facility – Telephone
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123) 456-7890.

Facility – Mailing Address same as Street Address?
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.

If "**Yes**", the Mailing Address, City, State and Zip Code will be automatically populated.

If "**No**", manually key in the following information
Mailing Address – Put in the Mailing Address for the facility (P. O. Box, Street, etc.)
Mailing City – Put in the City for the facility
Mailing State – **DO NOT KEY in this field**. Make the selection from the "drop" box.
Mailing Zip Code – Put in the facility's zip code. The 4 digit extension may also be added if available.

Schedule A – Identification **(cont.)**	Preparer	Required Fields - Yes

The person that prepared this form information should go here.

Preparer – Name
Enter in the name of the person who prepared the form.

Preparer – Title
Enter in the work title of the person who prepared the form i.e. Supervisor, etc.

Preparer – Phone
This is a 10 digit field. Enter the telephone number starting with the area code, i.e. 1234567890. **DO NOT** use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

Preparer – E-Mail Address
Enter in a valid work e-mail address of the person who prepared the "JAR" form.

Schedule A – Identification **(cont.)**	Reporting Period	Required Fields - Yes

In the event your organizations' reporting period is different from that of our January 1st through December 31st, 2014 requested reporting period, due to your facility having newly opened or your facility having closed prior to December 31st; please provide the data including the actual beginning and ending dates for the period of time you are reporting for your facility.

Reporting Period – <u>Is the Reporting Period from January 1st through December 31st of the year specified above?</u>
This is a Required Field and must be answered with "Yes" or "No". **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If **"Yes",** the Beginning and Ending date fields will be automatically populated.

If **"No"**, then key in the dates. The format for the Beginning and Ending date is MMDDYYYY.

*If the reporting year is contained within a Leap Year, please use 366 reporting days. Example the year 2012 was a Leap Year.

Schedule A – Identification **(cont.)**	Administration	Required Fields - Yes

Administration – Administrator's Name
Put in Administrator's Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

Administration – Medical Director's Name
Enter in the Medical Director's Name of facility along with any title if present or applicable, i.e. RN, Dr., etc.

Schedule B – Organization Structure	Owner	Required Fields – Yes

Owner – <u>Name</u>
Put in the owners' complete Name (along with suffix if applicable).

Owner – <u>Street</u>
Put in the owner's Street address. This may also include Apt. No., P. O. Box, etc.

Owner – <u>City</u>
Put in the owner's City.

Owner –<u>State</u>
<u>DO NOT KEY in this field.</u> Make the selection from the **"drop"** box for this field.

Owner – <u>Zip Code</u>
Put in the owner's zip code. The 4 digit extension may be added if available.

Owner – <u>Telephone</u>
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

Schedule B – Organization Structure **(cont.)**	Owner Type	Required Fields – Yes

The type of legal entity, except proprietorship, general partnerships and government entities, can be confirmed by entering the legal entity's name into a search at the Secretary of State web site: http://www.tennesseeanytime.org/soscorp/.

Owner Type – For Profit
Select only one from this group. A "drop box" is provided to place an **"X**" beside the selection. If you choose one from this group DO NOT choose another from another group.

Owner Type – Not For Profit
Select only one from this group. A "drop box" is provided to place an **"X"** beside the selection. If you choose one from this group DO NOT choose another from another group.

Owner Type – Government*
Select only one from this group. A "drop box" is provided to place an **"X"** beside the selection. If you choose one from this group DO NOT choose another from another group.

**Other Government, Specify:* Information must be provided for this field if selected.

Schedule B – Organization Structure **(cont.)**	Managed By	Required Fields – Yes

Select only one from this group. *A "drop box" is provided to place an* ***"X"*** *beside the selection. If you choose one from this group DO NOT choose one from another group.*

Management Provided By – Owner
Please give Management Name. No other information is required.

Management Provided By – Contract with Firm

Name – Put in Firm Name

Street – Put in Firm Street

City -–– Put in Firm City

State – **DO NOT KEY in this field.** Make the selection from the **"drop"** box for this field.

Zip Code – Put in Firm 5 digit Zip Code. The 4 digit extension may also be given if available

Phone Number – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

Management Provided By – Other (Specify)

Name – Put in Other Name

Street – Put in Other Street

City -–– Put in Other City

State – **DO NOT KEY in this field.** Make the selection from the **"drop"** box for this field.

Zip Code – Put in Other 5 digit Zip Code. The 4 digit extension may also be given if available

Phone Number – This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. This field will automatically place the number in the telephone format (123)456-7890.

Schedule B – Organization Structure **(cont.)**	Building Owner	Required Fields – Yes

Building Owner – Name
Put in the building owners' Name.

Building Owner – Street
Put in the building owner's Street.

Building Owner – City
Put in the building owner's City.

Building Owner – State
DO NOT KEY in this field. Make the selection from the **"drop"** box for this field.

Building Owner – Zip Code
Put in the owner's zip code. The 4 digit extension may also be added if available.

Building Owner – Telephone
This is a 10 digit field. Key the telephone number starting with the area code, i.e. 1234567890. Do not use brackets or dashes. This field will automatically place the number in the telephone format (123)456-7890.

Schedule B – Organization Structure **(cont.)**	Building	Required Fields – Yes

Building – <u>Do you know the year of the original Construction Date?</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box.

If **"Yes"**, the **Year** must be keyed in. The format for Year is **"YYYY".**

If **"No"**, leave blank.

Building – <u>Has the building had a major renovation?</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box.

If **"Yes"**, the **Year** must be keyed in. The format for Year is **"YYYY".**

If **"No"**, leave blank.

Schedule B – Organization Structure **(cont.)**	Type of Facility	Required Fields – Yes

*Please check Yes or No in **each** of the four types to describe your facility and include the information requested for that type.*

Type of Facility – <u>Free-Standing</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

Type of Facility – <u>Hospital Based</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
State: **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

Type of Facility – <u>Doctor's Office</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
State: **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

Type of Facility – <u>Other</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If ***"Yes",*** provide the Name, Street, City, State and Zip Code**.**
State: **<u>DO NOT KEY in this field.</u>** Make the selection from the **"drop"** box for this field.

If "**No"**, leave blank.

Schedule B – Organization Structure **(cont.)**	Type of Service	Required Fields – Yes

Type of Service – <u>Multi-Specialty</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. . No other information is required.

Type of Service – <u>Limited-Purpose</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

Type of Service – <u>Cancer Treatment and Radiation Clinic</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. No other information is required.

Type of Service – <u>Other, Specify</u>*
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

*If **"Yes",** please provide description of Type of Service.

*If **"No"**, leave blank.

Schedule C – Licensure, Certifications, Accreditation	Certifications	Required Fields – Yes

Certifications – <u>Participation in TennCare</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, enter the Provider Number.
If **"No"**, leave blank.

Certifications – <u>Participation in Medicare</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, enter the Provider Number.
If **"No"**, leave blank.

Schedule C – Licensure, Certifications, Accreditation (cont.)	Accreditation and Audits	Required Fields – Yes

Accreditation and Audits – <u>Joint Commission on Accreditation of Healthcare Organizations (JCAHO)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>Clinical Laboratory Improvement Amendments (CLIA)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>Laboratory Proficiency Testing</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>American Association of Blood Banks (AABB)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>American Osteopathic Association (AOA)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Schedule C – Licensure, Certifications, Accreditations **(cont.)**	Accreditation and Audits	Required Fields – Yes

Accreditation and Audits – <u>College of American Pathologist (CAP)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>American College of Radiology (ACR)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If **"Yes"**, provide the Approval Year and Expiration Year. The format for Year is "YYYY".
If **"No"**, leave blank.

Accreditation and Audits – <u>Other, Specify 1, 2, and 3.</u>*
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

*If **"Yes"**, must specify other services in corresponding cell. Provide the Approval Year and Expiration Year. The format for Year is "YYYY".
*If **"No"**, leave blank.

Schedule D – Availability and Utilization of Svcs/Equip	Cardiopulmonary	Required Fields – Yes

Please provide information requested and indicate the number of patients and diagnostic procedures for those services during the reporting period. Number of patients may include duplicates because the same patient may receive several of the services listed. Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.

Cardiopulmonary Type of Service – Electroencephalogram (EEG)
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Cardiopulmonary Type of Service – Electrocardiogram (EKG)
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Cardiopulmonary Type of Service – Holter Monitoring
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Cardiopulmonary Type of Service – Exercise Tolerance Testing
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Cardiopulmonary Type of Service – Cardiac Catheterization
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Svcs/Equip (cont.)	Cardiopulmonary	Required Fields – Yes

Cardiopulmonary Type of Service – <u>Percutaneous Transiuminal Coronary Angioplasty</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Services/Equip (cont.)	Radiology *Type of Service*	Required Fields – Yes

Radiology Type of Service – <u>Radiography (Diagnostic and Special Procedures-e.g. Angiography)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Service <u>– Ultrasound (General/Vascular/Cardiac)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Service – <u>Nuclear Medicine</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Services/Equip (cont.)	Radiology *Type Equipment*	Required Fields – Yes

Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.

Radiology Type of Equipment on Site –Position Emission Tomography (PET scan)
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site – Computed Tomography (CT Scan)
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site – Ultrafast CT
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site – Magnetic Resonance Imaging (MRI)
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site – Hi Field MRI and Open MRI
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Services/Equip (cont.)	Radiology *Type Equipment*	Required Fields – Yes

Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report. **

Radiology Type of Equipment on Site –Megavoltage Radiation Therapy
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site –Stereotactic Procedure (including Breast Biopsy)**
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Radiology Type of Equipment on Site – Mammography**
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter number of Fixed plus Mobile Patients and/or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Services/Equip (cont.)	Other *Type of Service*	Required Fields – Yes

Other Type of Service – <u>Vascular Embolization</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Other Type of Service – <u>Anesthesia</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Other Type of Service – <u>Ultrasound (ACR Accredited Breast/Pelvic/OB)</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.
Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Other Type of Service – <u>Chemotherapy</u>
<u>DO NOT KEY in this field.</u> This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field. Enter number of Patients and Procedures.*
***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Svcs/Equip (cont.)	Other *Type Equipment*	Required Fields – Yes

Mobile units are units regularly transported to your facility that are not installed for daily use. Do not report equipment, patients or procedures already reported on a hospital Joint Annual Report.

Other Type of Equipment on Site – Lithotripsy
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Other Type of Equipment on Site – Bone, Densitometry
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If "**Yes"**, enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures.*

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Other Type of Equipment on Site – Other, Specify
DO NOT KEY in this field. This is a Required Field and must be answered with "Yes" or "No". Make the selection from the "drop" box for this field.

If "**Yes**", provide Other description for Type of Service. Enter Number of Units Fixed and/or Mobile. If Mobile, enter number of days. Enter number of Fixed plus Mobile Patients and /or Procedures. ***Procedures must equal or exceed number of Patients.***

***DO NOT ENTER ZERO** in these fields. Blank fields represent zero (0) for **ALL** fields.

Schedule D – Availability and Utilization of Svcs/Equip (cont.)	Total and Rooms	Required Fields – Yes

Total – Number of patients and diagnostic procedures during this reporting period.
DO NOT KEY in this field. This field is cumulative of the Cardiopulmonary, Radiology, and Other field of patients and diagnostic procedures.

Total – <u>Unduplicated patients</u>***
This is a Required Field. The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported. **DO NOT ENTER ZERO** in this field. Blank fields represent zero patients and/or procedures.

Rooms – <u>Number of Diagnostic Procedure rooms</u>
This is a Required Field and must be answered.

***This count must MATCH Total Patients Served. See page 34.**

Schedule E –Patient Characteristics	Number of Patients Served	Required Fields – Yes

Number of Patients Served By Age – <u>Gender</u>
DO NOT ENTER ZERO in these fields. Provide Age by Gender information. Blank fields represent zero patients.

Number of Patients Served By Age – <u>Race</u>
DO NOT ENTER ZERO in these fields. Provide Age by Race information. Blank fields represent zero patients.

Number of Patients Served - <u>Total Patients Served</u>***
This is a calculated field of Patient Age by Gender and Race. Patients by Gender must equal to Patients by Race for each Age group represented.

Schedule E –Patient Characteristics (cont.)	Number of Patients TN Origin	Required Fields – Yes

Number of Patients Served – <u>Tennessee Patients</u>
DO NOT ENTER ZERO in these fields. Please record the number of Tennessee patients who received services during the reporting period in the corresponding county cells. Blank fields represent zero patients.

Number of Patients Served – <u>Total Tennessee Patients</u>
This is a calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the patient county cells.

Schedule E –Patient Characteristics (cont.)	Number of Patients Out of State Origin	Required Fields – Yes

Number of Patients Served – <u>Out-of-state & Other State or Country Patients</u>
DO NOT ENTER ZERO in these fields. Please record the number of Out-of-state and or Other State/Country patients who received services during the reporting period in the corresponding cells. Blank fields will represent zero patients.

Number of Patients Served – <u>Total Non-Tennessee Patients</u>
This is a calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the Out-of-state and or Other State/Country fields.

Number of Patients Served – <u>Total Tennessee and Non-Tennessee Patients</u>****
This is a cumulative calculated field. The number "0" will automatically appear in the corresponding cell until data is placed in the County, Out-of-state, and Other State or Country fields.

*******This total must equal the <u>Total Patient Served field</u> in Schedule E***

Schedule F –Financial Data	Expenses	Required Fields – Yes

Expenses – <u>Payroll</u>
Include salaries for all full-time and part-time personnel who are included in Schedule G.
This is a required field. Data must be placed in this field. <u>This field will accept zero (0).</u>

Expenses – <u>Fringe Benefits</u>
Social Security, group insurance, retirement benefits, etc.
This is a required field. Data must be placed in this field. <u>This field will accept zero (0).</u>

Expenses – <u>Other Operating Expenses</u>
These are expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.) and all other operating expenses.
This is a required field. Data must be placed in this field. <u>This field will accept zero (0).</u>

Expenses – <u>Depreciation Expense</u>
This is a required field. Data must be placed in this field. <u>This field will accept zero (0).</u>

Expenses – <u>Non-Operating Expenses</u>
Include all other expenses for interest, taxes, real estate ease expenses, and other non-operating expenses.
This is a required field. Data must be placed in this field. <u>This field will accept zero (0).</u>

Schedule F –Financial Data	Patient Revenue	Required Fields – Yes

Government – Gross Patient Charges
This is the sum of the facility's established rate for all services rendered to patients during the reporting year. *Show the revenue source from Medicare, TennCare, and Other Government.*
This is a required field. If there are no transactions enter zero (0).

Government – Adjustment to Charges
The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year's revenue (Medicare or TennCare) should be reported as non-operating revenue, **not as current year adjustments**.
Show the revenue source from Medicare, TennCare, and Other Government.
This is a required field. If there are no transactions enter zero (0).

Government – Total Government Gross Patient Charges and Adjustment to Charges
This is a cumulative calculated field of Gross Patient Charges and Adjustment to Charges field. The number "0" will automatically appear in this cell until an amount is placed in these fields.

Non-Government – Gross Patient Charges
This is the sum of the facility's established rate for all services rendered to patients during the reporting year. *Show the charges are from "Self-Pay", Insurance, Other Non-Government.*
This is a required field. If there are no transactions enter zero (0).

Non-Government Revenue Source – Adjustment to Charges
The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period should be reported here. Adjustments to previous year's revenue (Medicare or TennCare) should be reported as non-operating revenue, not as current year adjustments.
Show the charges are from "Self-Pay", Insurance, Other Non-Government.
This is a required field. If there are no transactions enter zero (0).

Non-Government Revenue Source – Total Non-Government
This is a cumulative calculated field of the Non-Government Gross Patient Charges and Non-Government Adjustment to Charges fields. The number "0" will automatically appear in this cell until an amount is placed in these fields.

Patient Revenue – Total Patient Revenue
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Total Government plus Total Non-Government* cells.

Should be below

The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

Patient Revenue – <u>All Non-Patient Revenue</u>
This is a required field. Data must be placed in this field. If there are no transactions enter zero (0).

Patient Revenue – <u>Net Patient Revenue</u>
This is a calculated field. The difference obtained by subtracting Adjustments to Charges from Gross Patient Charges. This difference represents the actual amount of revenue that the facility received.

Patient Revenue – Total Net Revenue: <u>Net Total Patient Revenue plus All Non-Patient Revenue</u>
This is a calculated field. This is the sum of the Total patient Revenue plus All Non-Patient Revenue.

Schedule F –Financial Data (cont.)	Non-Government Adjustment	Required Fields – Yes

Non-Government Adjustment – <u>Bad Debt</u>
Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay.
This is a required field. If there are no transactions enter zero (0).

Non-Government Adjustment – <u>Charity Care</u>
Services provided to medically needy persons for which the facility does not expect payment.
This is a required field. If there are no transactions enter zero (0).

Non-Government Adjustment – <u>Other</u>
Any other adjustments that are not appropriately reported in either Bad Debt or Charity
This is a required field. If there are no transactions enter zero (0).

Non-Government Adjustment –<u>Total Non-Government Adjustment to Charges Subcategories</u>
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the Bad Debt, Charity Care, and Other cells.

Schedule G – Personnel	Type of Personnel by Service	Required Fields – Yes

Please indicate the number of paid personnel as of the last day of reporting period. Do not include a type of personnel for which you do not provide that type of service. For example, do not include Physical Therapist unless you provide Physical Therapy Services.

Full Time Equivalent (FTE)

Part-time is the Number of hours worked by part-time employees per week/40.

Example: Three Registered Nurses, each working 20 hours a week, the FTE would be (3X20)/40=1.5.

Additional Example of FTE

40 Hours = 1.00
30 Hours = .75
20 Hours = .50
10 Hours = .25

For the purpose of this calculation if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE.

The sum of full-time personnel plus part time personnel (in full-time equivalents) added together equals the total number of full-time equivalents.

Type Administrators – Employee and Contract – Full-Time / Part-Time

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Medical Director – Employee and Contract – Full-Time / Part-Time

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Physicians (M.D. and D. O.) – Employee and Contract – Full-Time / Part-Time

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Dentist – Employee and Contract – Full-Time / Part-Time

Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Schedule G – Personnel (cont.)	Type of Personnel by Service	Required Fields – Yes

Type Financial/Billing Personnel – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Nursing (R.N., L.P.N., and Ancillary) – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Medical Records – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Registered Technologist – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Technical – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type Maintenance/Services – <u>Employee and Contract – Full-Time / Part-Time</u>
Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Schedule G – Personnel (cont.)	Type of Personnel by Service	Required Fields – Yes

Type Other 1, 2, and 3 Specify – <u>Employee and Contract – Full-Time / Part-Time</u>
Supply name of other service if indicated. Use the formula for FTE to determine number of persons that represent each column. Full-time is represented in whole numbers. Part-Time is represented in numbers with two decimal points in FTE. **Leave the item BLANK if the value is unknown or zero (0).**

Type – <u>Total Number of Personnel by Type</u>
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Employee Full-Time, Employee Part-Time, Contract Full-Time, and Contract Part-Time cells separately.*

Schedule G – Personnel (cont.)	Nursing Personnel – RN	Required Fields – Yes

Please indicate the number of personnel as of the last day of the reporting period.

Registered Nurses – Highest Education Level – Number Currently Employed
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Registered Nurses – Highest Education Level – Number of Budgeted Vacancies
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Registered Nurses – Highest Education Level – Average Number of Weeks Required to Recruit Staff
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Registered Nurses – Highest Education Level – Number Added in Past 12 Months
Associate, Diploma, Bachelors, Masters, and Doctorate: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Registered Nurses – Highest Education Level – Number Eliminated in Past 12 Months
Associate, Diploma, Bachelors, Masters, and Doctorate employed in Clinical and Administration: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Registered Nurses – Highest Education Level – Total
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Number Currently Employed, Number Budgeted Vacancies, Number Added in Past 12 Months, and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

Schedule G – Personnel (cont.)	Nursing Personnel – Advanced	Required Fields – Yes

Please indicate the number of personnel as of the last day of the reporting period.

Advanced Practical Nurses – Category – Number Currently Employed
Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Advanced Practical Nurses – Category – Number of Budgeted Vacancies
Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Advanced Practical Nurses – Category – Average Number of Weeks Required to Recruit Staff
Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Advanced Practical Nurses – Category – Number Added in Past 12 Months
Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Advanced Practical Nurses – Category – Number Eliminated in Past 12 Months
Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Clinical and Administration: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Advanced Practical Nurses – Category – Total
This is a cumulative calculated field. The number "0" will automatically appear in this cell and sums the amounts in the *Nurse Practitioner, Clinical Nurse Specialist, and Certified Registered Nurse Anesthetist employed in Number Added in Past 12 Months and Number Eliminated in Past 12 Months (Clinical and Administrative) cells separately.*

Schedule G – Personnel (cont.)	Nursing Personnel – Other	Required Fields – Yes

Please indicate the number of personnel as of the last day of the reporting period.

Other Nurses – Other Nursing Staff – Number Currently Employed
Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Other Nurses – Other Nursing Staff – Number of Budgeted Vacancies
Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Other Nurses – Other Nursing Staff – Average Number of Weeks Required to Recruit Staff
Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2,Specify: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Other Nurses – Other Nursing Staff – Number Added in Past 12 Months
Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Other Nurses – Other Nursing Staff – Number Eliminated in Past 12 Months
Licensed Practical Nurses, Certified Nurses' Aides, Other 1, Specify, Other 2, Specify: Indicate number of personnel as of the last day of reporting period. If data is given for ***Other 1 or 2***, please describe the Other Nursing Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Schedule G – Personnel (cont.)	Nursing Personnel – Contract	Required Fields – Yes

Please indicate the number of personnel as of the last day of the reporting period.

Contract Nursing – Does your organization use contract nursing personnel?
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.

If **"Yes"**, indicate the number of contract personnel in the categories below.
If **"No"**, continue to the next schedule. Leave fields blank.

Contract Nursing – Number Currently Employed
Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Contract Nursing – Number of Budgeted Vacancies
Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Contract Nursing – Average Number of Weeks Required to Recruit Staff
Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Contract Nursing – Number Added in Past 12 Months
Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Contract Nursing – Number Eliminated in Past 12 Months
Registered Nurses, Licensed Practical Nurses, and Certified Nurses' Aides: Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Schedule H – Personnel	Medical Staff	Required Fields – Yes

Please include all physicians, whether considered active or associate.
Active: Employed and practicing at the facility.
Associate: Has privileges to practice at the facility but is not employed at the facility.

Medical Staff – Specialty – Total number of Medical Staff
Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify): Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Medical Staff – Specialty – Number of Medical Staff who are Board Certified
Cardiologist, Neurologist, Pathologist, Radiologist, Technician, Other 1 (specify), Other 2 (specify): Indicate number of medical staff as of the last day of reporting. If data is given for ***Other 1 or 2***, please describe the Other Medical Staff for that field. Indicate number of personnel as of the last day of reporting period. **DO NOT enter zero (0). Blank field represents zero (0) personnel.**

Schedule Adm. Dec. – Administrator's Declaration	Administrator's Declaration	Required Fields – Yes

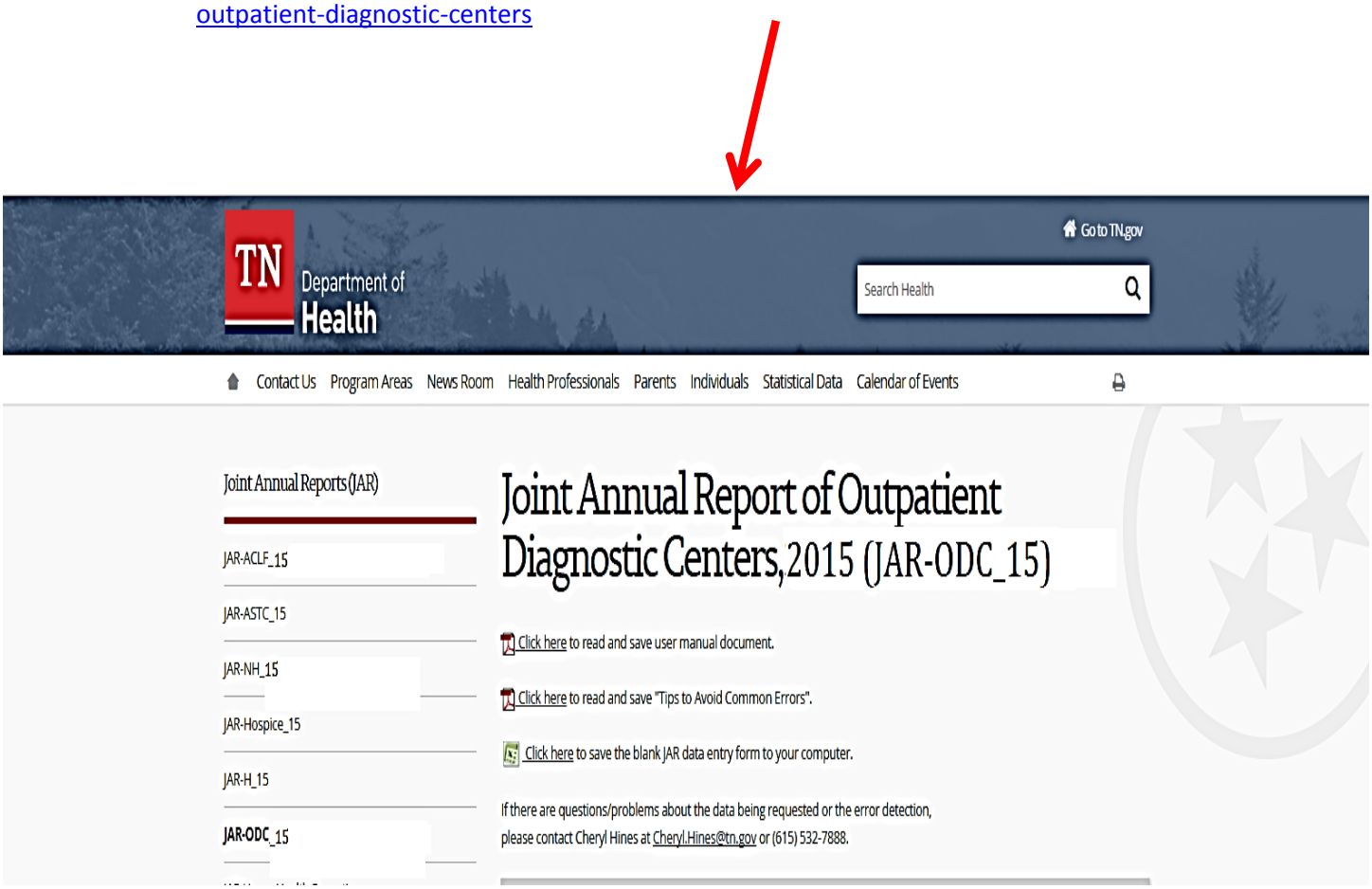
Administrator Declaration – "I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete."
This is a Required Field and must be answered with "Yes" or "No". **DO NOT KEY in this field.** Make the selection from the "drop" box for this field.
If the answer is "Yes", then key the date acknowledged. The format is MM/DD/YYYY.

Appendix

The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

"Saving your Joint Annual Report Form"

2. Go to the JAR ODC Website: https://www.tn.gov/health/article/joint-annual-report-of-outpatient-diagnostic-centers

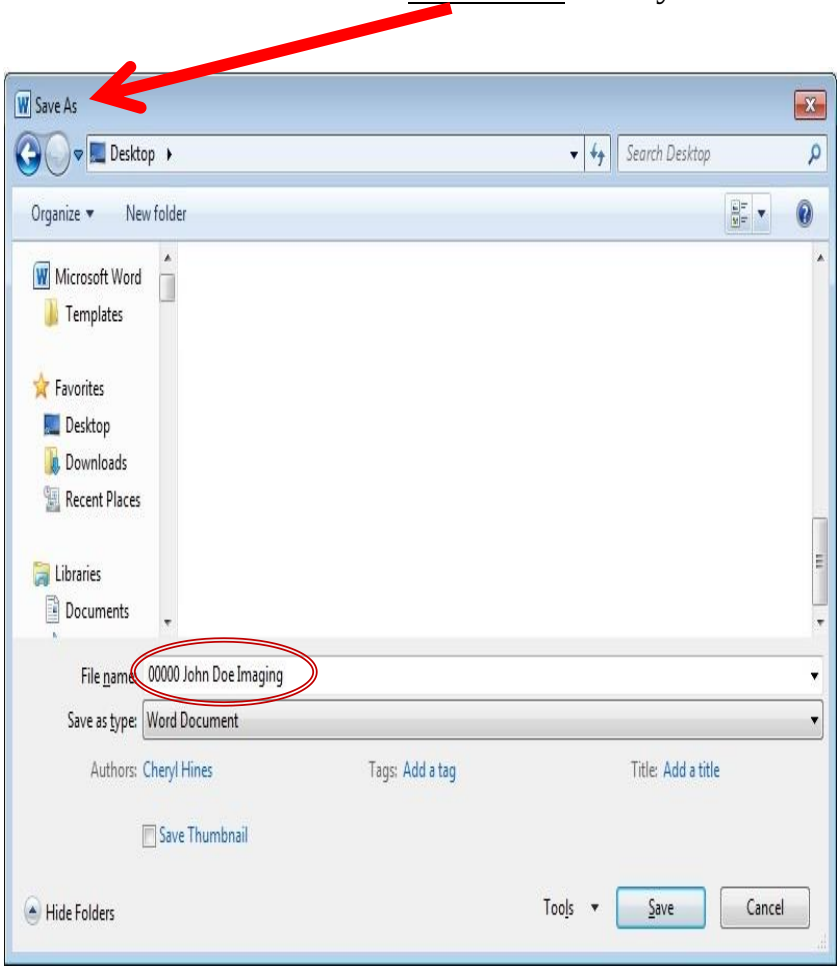


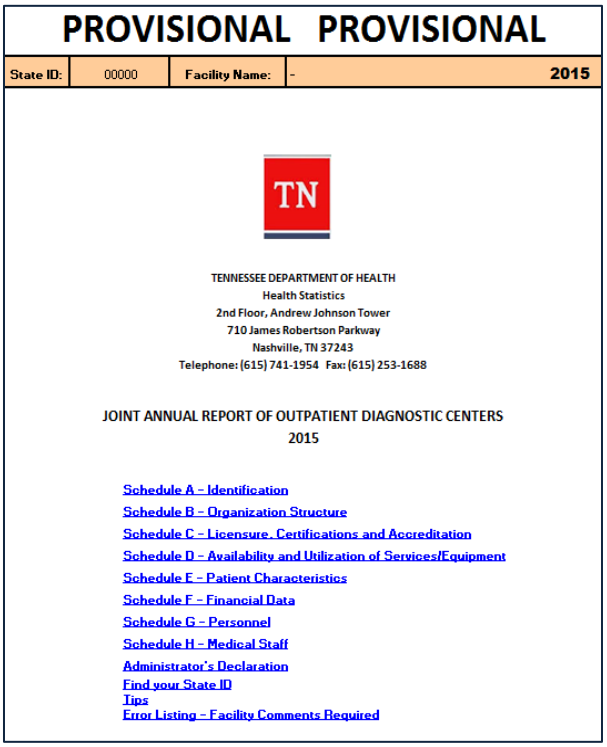
"Saving your Joint Annual Report Form"

3. Select: **Click here to save the Blank "JAR" data entry form to your computer.**

"Saving your Joint Annual Report Form"

4. Select File: **SAVE AS** from your menu bar:





PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

JOINT ANNUAL REPORT OF OUTPATIENT DIAGNOSTIC CENTERS
2015

Schedule A – Identification
Schedule B – Organization Structure
Schedule C – Licensure, Certifications and Accreditation
Schedule D – Availability and Utilization of Services/Equipment
Schedule E – Patient Characteristics
Schedule F – Financial Data
Schedule G – Personnel
Schedule H – Medical Staff
Administrator's Declaration
Find your State ID
Tips
Error Listing – Facility Comments Required

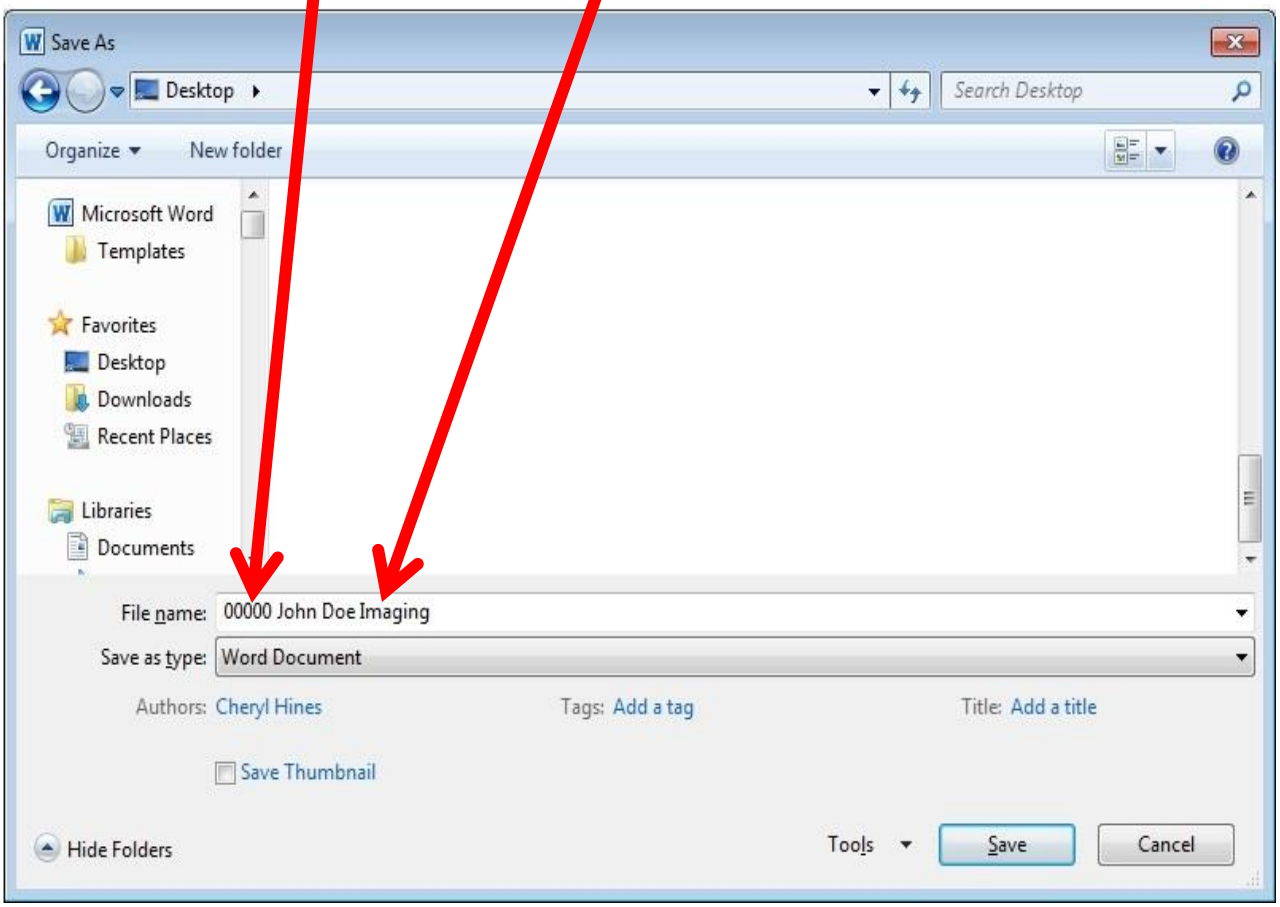
The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

"Saving your Joint Annual Report Form"

5. **NAME** your Joint Annual Report "JAR" Files as:

Example: 00000 John Doe Imaging

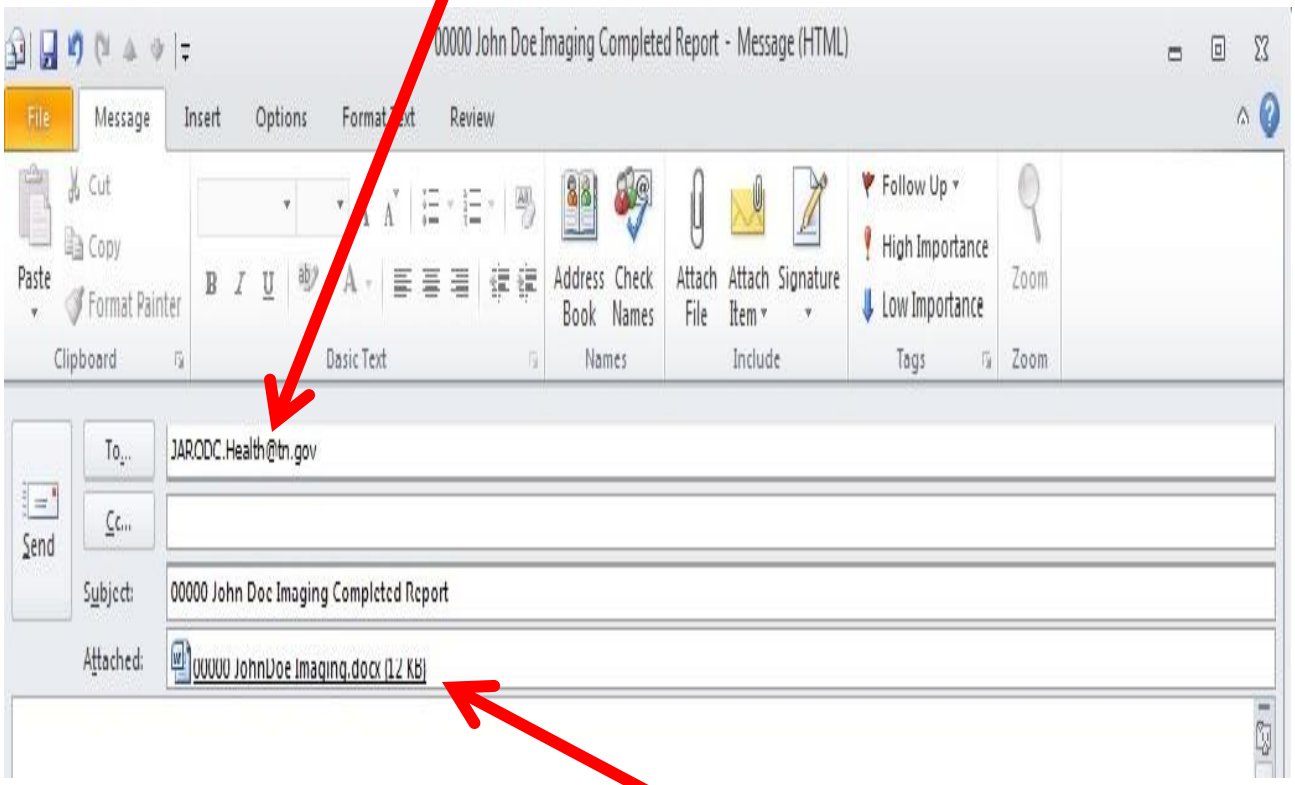
State ID Number Your Facility Name



"Saving your Joint Annual Report Form"

6. After having downloaded, saved and completed your facility's ODC Joint Annual Report "JAR" Form. It is time to EMAIL an attached copy of the completed form to the below email address:

EMAIL TO: JARODC.health@tn.gov



Please include your saved attached file named as:

Example: 00000 John Doe Imaging

State ID Number Your Facility Name

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PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

TENNESSEE DEPARTMENT OF HEALTH
Health Statistics
2nd Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243
Telephone: (615) 741-1954 Fax: (615) 253-1688

JOINT ANNUAL REPORT OF OUTPATIENT DIAGNOSTIC CENTERS
2015

The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule A - Identification

According to the Department of Health Rules and Regulations Section 1200-8-35-.11 "the Joint Annual Report of Outpatient Diagnostic Centers shall be filed with the department." Please read all information carefully before completing your Joint Annual Report with data for the calendar year indicated on the first page. Please complete all items on the Joint Annual Report. Use 0 (zero) when appropriate. Check all computations, especially where a total is required. Please check all checkboxes. Any items which appear to be inconsistent will be queried. **Facilities will be reported to the Board for Licensing Healthcare Facilities for both failure to file forms and failure to respond to queries.** A section for comments relating to the unique aspect of your agency is available at the end of each schedule.

Facility	State ID	00000		
	ODC Name	-		
	Did the facility name change during the reporting period? Yes/No	-		
	If Yes, Prior Name			
	Street Address	-		
	City	-	County	-
	State		Zip Code (5 digit)	-
	Phone			
	Mailing Address same as Street Address? If Yes, proceed to next section. Yes/No	-		
	Mailing Address			
	City			
	State		Zip Code (5 digit)	
Preparer	Name		Phone	
	Title			
	E-Mail			

Reporting Period	In the event your reporting period differs from that of January 1 through December 31 and/or is less than 365 days, due to new opening or a facility closure, please provide the data along with the beginning and ending dates for the period of time you are reporting.		
	Is the reporting period January 1 - December 31 of the year specified above? Yes/No		No
	If unable to report based on above dates, provide beginning and ending dates (used for all utilization and financial data):	Beginning (mm/dd/yyyy)	
		Ending (mm/dd/yyyy)	

Administration	Administrator's Name	
	Medical Director's Name	

Go to Next Schedule

Return to Main Menu

Go to Error Listing

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule B - Organization Structure

	ment	^	Federal			
		^	Other Government, Specify			
Managed by	Management is provided by:		If managed by contract or other, provide information below			
	^	Owner	Name			
	^	Contract with Firm	Street			
	^	Other, Specify	City		Phone	
			State		Zip Code	
Building Owner	Name					
	Street					
	City			Phone		
	State			Zip Code		
Building	Yes/No	-	Do you know the year of the original construction date? If yes:		Year	
	Yes/No	-	Has the building had a major renovation? A major renovation is any project that includes the addition of services or medical equipment. If Yes, provide year.		Year	
Type of Facility	Please check Yes or No in each of the four types to describe your facility and include the information requested for that type.					
	Yes/No	-	Free-Standing			
	Yes/No	-	Hospital Based	Name		
				Street		
				City		
				State	Zip Code	
	Yes/No	-	Doctor's Office	Name		
				Street		
				City		
				State	Zip Code	
	Yes/No	-	Other	Specify		
				Name		
				Street		
				City		
				State	Zip Code	
Type of Service	Yes/No	-	Multi-Specialty			
	Yes/No	-	Limited-Purpose			
	Yes/No	-	Cancer Treatment and Radiation Clinic			
	Yes/No	-	Other, specify			

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State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers – Schedule C – Licensure, Certifications and Accreditation

Certifications	Yes/No	-	Participation in TennCare	Provider Number	
	Yes/No	-	Participation in Medicare	Provider Number	
Accreditation and Audits	Yes/No	-	Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Approval Year	
				Expiration Year	
	Yes/No	-	Clinical laboratory Improvement Amendments (CLIA)	Approval Year	
				Expiration Year	
	Yes/No	-	Laboratory Proficiency Testing	Approval Year	
				Expiration Year	
	Yes/No	-	American Association of Blood Banks (AABB)	Approval Year	
				Expiration Year	
	Yes/No	-	American Osteopathic Association (AOA)	Approval Year	
				Expiration Year	
	Yes/No	-	College of American Pathologists (CAP)	Approval Year	
				Expiration Year	
	Yes/No	-	American College of Radiology (ACR)	Approval Year	
				Expiration Year	
	Yes/No	-	Other (1), specify	Approval Year	
				Expiration Year	
	Yes/No	-	Other (2), specify	Approval Year	
				Expiration Year	
	Yes/No	-	Other (3), specify	Approval Year	
				Expiration Year	

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State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule D - Availability and Utilization of Services/Equipment

Cardio-pulmonary	Electroencephalogram (EEG)						
	Electrocardiogram (EKG)	-					
	Holter Monitoring	-					
	Exercise Tolerance Testing	-					
	Cardiac Catheterization	-					
	Percutaneous Transiuminal Coronary Angioplasty	-					
Radiology	Type of Service	Yes/No				Patients	Procedures
	Radiography (Diagnostic and Special Procedures- e.g. Angiography)	-					
	Ultrasound (General/Vascular/Cardiac)	-					
	Nuclear Medicine	-					
	Type of Equipment on Site	Yes/No	Number of Units		If Mobile, number of days per week	Fixed plus Mobile	
			Fixed	Mobile		Patients	Procedures
	Positron Emission Tomography (PET scan)	-					
	Computed Tomography (CT scan)	-					
	Ultrafast CT	-					
	Magnetic Resonance Imaging (MRI)	-					
	Hi-Field MRI and Open MRI	-					
	Megavoltage Radiation Therapy	-					
	Stereotactic Procedure (including breast Biopsy)	-					
	Mammography	-					

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule D - Availability and Utilization of Services/Equipment

Other	Vascular Embolization	-					
	Anesthesia	-					
	Ultrasound (ACR Accredited Breast/ Pelvic/OB)	-					
	Chemotherapy	-					
	Type of Equipment on Site	Yes/No	Number of Units		If Mobile, number of days per week	Fixed plus Mobile	
			Fixed	Mobile		Patients	Procedures
	Lithotripsy	-					
	Bone Densitometry	-					
	Other, Specify	-					
Total	Total number of patients and diagnostic procedures during this reporting period.					0	0
	Total Unduplicated Patients: The number of actual individuals served during the reporting period. This may be less than the number of patients and diagnostic procedures reported.						
Rooms	Number of Diagnostic Procedure rooms.						

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PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule E - Patient Characteristics

Do not enter zero. Blank fields will represent zero patients.

	Age	Gender		Total Patients Served	Race		
		Male	Female		White	Black	Other
Number of Patients Served By Age, Gender, and Race	17 and Under			0			
	18-64			0			
	65-84			0			
	85 and Older			0			
	Total Patients	0	0	0	0	0	0
	Total Patients Served should match Total Urduplicated Patients in Schedule D.						

Please record the number of Tennessee and Non-Tennessee patients who received services during the reporting period.

Number of Patients Served by Patient Origin

Tennessee Patients

County	Number of Patients	County	Number of Patients	County	Number of Patients
1 Anderson		33 Hamilton		65 Morgan	
2 Bedford		34 Hancock		66 Obion	
3 Benton		35 Hardeman		67 Overton	
4 Bledsoe		36 Hardin		68 Perry	
5 Blount		37 Hawkins		69 Pickett	
6 Bradley		38 Haywood		70 Polk	
7 Campbell		39 Henderson		71 Putnam	
8 Cannon		40 Henry		72 Rhea	
9 Carroll		41 Hickman		73 Roane	
10 Carter		42 Houston		74 Robertson	
11 Cheatham		43 Humphreys		75 Rutherford	
12 Chester		44 Jackson		76 Scott	
13 Claiborne		45 Jefferson		77 Sequatchie	
14 Clay		46 Johnson		78 Sevier	
15 Cocke		47 Knox		79 Shelby	
16 Coffee		48 Lake		80 Smith	
17 Crockett		49 Lauderdale		81 Stewart	
18 Cumberland		50 Lawrence		82 Sullivan	
19 Davidson		51 Lewis		83 Sumner	
20 Decatur		52 Lincoln		84 Tipton	
21 DeKalb		53 Loudon		85 Trousdale	
22 Dickson		54 McMinn		86 Unicoi	
23 Dyer		55 McNairy		87 Union	
24 Fayette		56 Macon		88 Van Buren	
25 Fentress		57 Madison		89 Warren	
26 Franklin		58 Marion		90 Washington	
27 Gibson		59 Marshall		91 Wayne	
28 Giles		60 Maury		92 Weakley	

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule E - Patient Characteristics

	29 Grainger		61 Meigs		93 White	
	30 Greene		62 Monroe		94 Williamson	
	31 Grundy		63 Montgomery		95 Wilson	
	32 Hamblen		64 Moore		96 Unknown	
					Total Tennessee Patients	**0**
Number of Patients Served by Patient Origin Out-of-state Patients	State	Number of Patients	State	Number of Patients	State	Number of Patients
	01 Alabama		18 Kentucky		34 North Carolina	
	04 Arkansas		25 Mississippi		47 Virginia	
	11 Georgia		26 Missouri		55 Other State or Country	
					Total Non-Tennessee Patients	**0**
					Total of Tennessee and Non-Tennessee Patients	**0**

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State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule F - Financial Data

Round all figures to the nearest dollar.		Amount
Expenses	Payroll - Include salaries for all full-time and part-time personnel who are included in Schedule G.	-
	Fringe Benefits - Social security, group insurance, retirement benefit, etc.	-
	Other Operating Expenses - Expenses for all contract staff, professional fees, energy expense (oil, natural gas, electricity, etc.), and all other operating expenses.	-
	Depreciation Expense.	-
	Non-Operating Expense - Include all other expenses for interest, taxes, real estate ease expenses, and other non-operating expenses.	-
	Total	**$0**

Patient Revenue

Gross Patient Charges - The sum of the facility's established rate for all services rendered to patients during the reporting year.
Adjustments to Charges - The difference between the gross patient charges and the actual amount of payment received by the facility during the reporting period. Adjustments to previous years revenue, such as Medicare or TennCare prior adjustments, should be reported as non-operating revenue, not as current year adjustments.
Net Patient Revenue - The difference obtained by subtracting adjustments to charges from gross patient charges. This difference represents the actual amount of revenue that the facility received.

	Revenue Source	Gross Patient Charges	-	Adjustment to Charges	=	Net Patient Revenue
Government	Medicare	-	-	-	=	#VALUE!
	TennCare	-	-	-	=	#VALUE!
	Other Government	-	-	-	=	#VALUE!
	Total Government	$0	-	$0	=	$0
Non-Government	Self-Pay	-	-	-	=	#VALUE!
	Insurance	-	-	-	=	#VALUE!
	Other Non-Government	-	-	-	=	#VALUE!
	Total Non-Government	$0	-	$0	=	$0
Total Patient Revenue: (Total Government plus Total Non-Government)		$0	-	$0	=	$0
All Non-Patient Revenue						-
Total Net Revenue: Net Total Patient Revenue plus All Non-Patient Revenue						**#VALUE!**

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - **Schedule F** - Financial Data

	All Non-Patient Revenue	-
	Total Net Revenue: Net Total Patient Revenue plus All Non-Patient Revenue	#VALUE!
Non-Government Adjustment to Charges Subcategories	Bad Debt - Uncompensated care for which the facility directly billed the patient and for which the patient should reasonably be expected to pay.	-
	Charity Care - Services provided to medically needy persons for which the facility does not expect payment.	-
	Other - Any other adjustments that are not appropriately reported in either Bad Debt or Charity.	-
	Total Non-Government Adjustment to Charges Subcategories	$0

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PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule G - Personnel

Do not enter zero. Blank fields will represent zero personnel.

Type of Personnel by Service

Please indicate the number of paid personnel as of the last day of the reporting period. Do not include a type of personnel for which you do not provide that type of service. For example, do not include Physical Therapists unless you provide Physical Therapy services.
Leave the item blank if the value is unknown. Full Time Equivalent (FTE) = Number of hours worked by part-time employees per week/40 hours per week. For example, three Registered Nurses, each working 20 hours a week, the FTE would be (3x20)/40=1.5. Additional examples of FTEs:
40 hours = 1 FTE; 30 hours = .75 FTE; 20 hours = .5 FTE; 10 hours = .25 FTE. For the purposes of this calculation, if your agency reimburses employees per visit rather than per hour worked, one visit equals one hour in FTE. The sum of full-time personnel plus part-time personnel (in full-time equivalents) added together equal the total number of full-time equivalents.

Type	Number of Personnel by type			
	Employee		Contract	
	Full-Time	Part-Time In FTE	Full-Time	Part-Time In FTE
Administrators				
Medical Director				
Physicians (M.D. And D.O.)				
Dentists				
Financial/Billing Personnel				
Nursing (R.N., L.P.N., and Ancillary)				
Medical Records				
Registered Technologist				
Technical				
Maintenance/Services				
Other 1, Specify				
Other 2, Specify				
Other 3, Specify				
Total	0	0.00	0	0.00

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule G - Personnel

Please indicate the number of personnel as of the last day of the reporting period.

		Highest Education Level	Number Currently Employed	Number of Budgeted Vacancies	Average # Weeks Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months	
							Clinical	Admin
Nursing Personnel	**Registered Nurses**	Associate						
		Diploma						
		Bachelors						
		Masters						
		Doctorate						
		Total	0	0		0	0	0
	Advanced Practice Nurses	Category	Number Currently Employed	Number of Budgeted Vacancies	Average # Weeks Required to Recruit Staff	Number Added in the Past 12 Months	Number Eliminated in the Past 12 Months	
							Clinical	Admin
		Nurse Practitioner						
		Clinical Nurse Specialist						
		Certified Registered Nurse Anesthetist						
		Total	0	0		0	0	0

PROVISIONAL PROVISIONAL

State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule G - Personnel

		Other Nursing Staff	Number Currently Employed	Number of Budgeted Vacancies	Average #Weeks Required to Recruit Staff	Number added in the Past 12 Months	Number Eliminated in the Past 12 Months
	Other Nurses	Licensed Practical Nurses					
		Certified Nurses Aides					
		Other 1, Specify					
		Other 2, Specify					
	Contract Nursing	**Yes/No** - Does your organization use contract nursing personnel?					
		If yes, indicate the number of contract personnel in the following categories:					
			Number Currently Employed	Number of Budgeted Vacancies	Average #Weeks Required to Recruit Staff	Number added in the Past 12 Months	Number Eliminated in the Past 12 Months
		Registered Nurses					
		Licensed Practical Nurses					
		Certified Nurse Aids					

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State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule H - Medical Staff

Do not enter zero. Blank fields will represent zero medical staff.

Include all physicians, whether considered active or associate.
Active: Employed and practicing at the facility
Associate: Has privileges to practice at the facility but is not employed at the facility

	Specialty		Total Number of Medical Staff	Number of Medical Staff who are Board Certified
Medical Staff	Cardiologist			
	Neurologists			
	Pathologist			
	Radiologist			
	Technician			
	Other 1, specify			
	Other 2, specify			

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State ID:	00000	Facility Name:	-	2015

Outpatient Diagnostic Centers - Schedule Adm Dec - Administrator's Declaration

-	**Have you Saved and Renamed the report with your State ID and Facility name as instructed? Example: "12345 ABC ODC_2015"**
-	**Have you Checked and Corrected all Errors on the Error Tab?**

Administrator's Declaration	-	I, the administrator, declare that I have examined this report and to the best of my knowledge and belief, it is true, correct, and complete.
Date (mm/dd/yyyy) (use slashes)		

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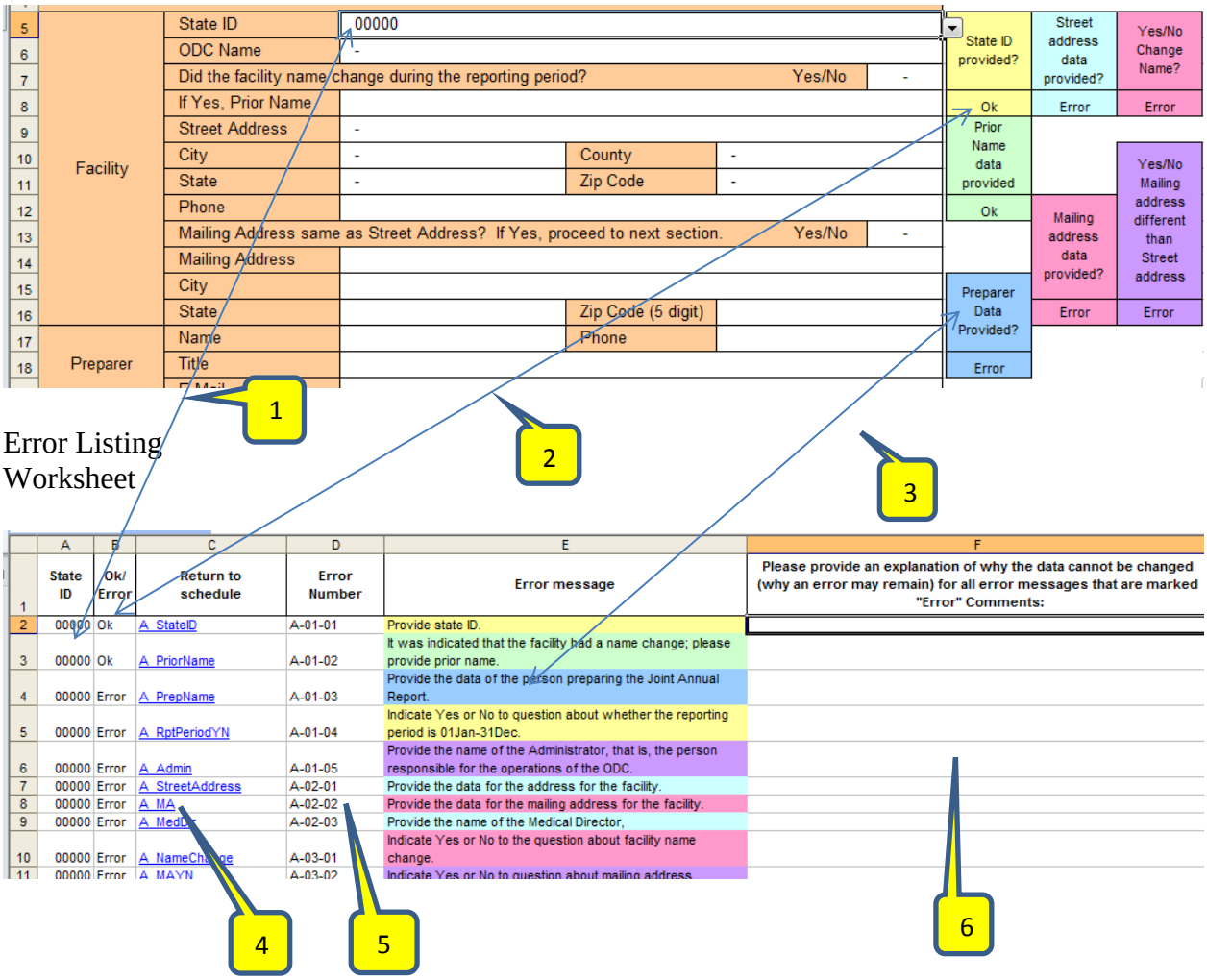
Printing – Each schedule can be printed individually. Please note if you print the entire file, you will print over 20 pages including the State ID's and Error listing worksheets.

Schedule A



Error Listing Worksheet

1. State ID from Schedule A will be populated by the system in column A of the Error Listing worksheet for each error question in the JAR.
2. Error message (Ok or Error) will be populated by the system from each error in all schedules.
3. Error message color will match on the schedule and in the Error Listing worksheet. A more detailed explanation of the error is in the Error Listing worksheet.
4. This is a hyperlink which will return you to the schedule with the error. The cell you are returned to will be the first possible cell where the error may reside; however, this cell may not contain the error in question.

The mission of the Department of Health is to protect, promote and improve the health and prosperity of people in Tennessee.

Printing continued

5. Error Number is a listing of the errors. The format for the error number A-01-02, A represents the schedule in this example A. 01 represents the first column of errors starting in column "AL". 02 represent the error number for the column in order from top to bottom.
6. Used to provide an explanation of why the data is not a true error.

Joint Annual Report of Outpatient Diagnostic Centers
2015 Tips to Avoid Common Errors

The following guidelines are written to assist you to complete the Joint Annual Report for the Outpatient Diagnostic Center 2013 reporting year.

A. A User Manual can be found on the website https://www.tn.gov/health/article/joint-annual-report-of-outpatient-diagnostic-centers Please read all information carefully before completing your Joint Annual Report. Keep the manual and these tips handy as you will need them to fill out the form and export the data. For your reference, this Tips document is also included as a Tab on the Excel data entry form.

B. Please complete all items on the report form.
   (1) Use 0 (zero) when appropriate rather than leaving the item blank.
   (2) Please select the appropriate answer to all (Yes / No) questions.
   (3) Check all computations, especially where a total is required.
   (4) Corporate offices that do data entry for several facilities must close out between each facility to avoid system generated errors. It is requested that you work on one (1) facility at a time.

   (5) In the event that a reporting period other than January1 through December 31 is used by your facility for statistical information, please report that data including the actual beginning and ending dates of your facilities' reporting period.

C. Any item which appears to be inconsistent will be queried. Report forms with items left blank will not be acceptable. ***The Tennessee Department of Health's Bureau of Health Licensure and Regulation may issue deficiencies for either failing to file forms or submission of incomplete forms.***

SCHEDULE A – IDENTIFICATION

Facility

State ID: Select your State ID from the drop down list first. Facility name and address are filled in automatically, unless there is a name change in which case your facility's new name and your facility's new address has to be typed in manually.

Reporting Period: All facilities are requested to report data based on the twelve month period for the calendar year. If reporting period is January 1 through December 31, leave date lines blank.

Use Proper Case and not ALL CAPS in Schedule A; such as facility name, address, and city.

Please fill in the e-mail address of the preparer of your facility's report, so that we may use this address as a means of initial contact.

SCHEDULE B – ORGANIZATION STRUCTURE

Owner Type

Please place an "X" in only **one** block of the For Profit, Not for Profit or Government Section.

SCHEDULE C – LICENSURE, CERTIFICATIONS AND ACCREDITATION

Please fill in provider numbers. The data field for year of accreditation/audit takes only the four digit year. Do not put in a complete date. Answer all Yes/No questions.

SCHEDULE D – AVAILABILITY AND UTILIZATION OF SERVICES/EQUIPMENT

Fill in the number of patients and diagnostic procedures and number of fixed and mobile units as well as number of days per week for mobile. The total unduplicated patients on this schedule should match the total patients by age, gender, and race in Schedule E.